



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TROPHY CLUB MEDICAL CENTER  
2850 E HIGHWAY 114  
TROPHY CLUB TX 76262-5302

#### **Respondent Name**

OLD REPUBLIC INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 44

#### **MFDR Tracking Number**

M4-11-4213-01

#### **MFDR Date Received**

July 19, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Claim not paid at 130% APC with implants at cost plus 10% Appealed 04/25/2011 Carrier denied on 06/03/11"

**Amount in Dispute:** \$40,304.43

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The insurance carrier did not submit a response for consideration in this review.

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2011	Outpatient Hospital Services	\$40,304.43	\$40,304.43

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
  - W4 – [No description of this explanation code found with the submitted documentation.]

## **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

## **Findings**

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are \$25,130.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 63685 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0039, which, per OPPS Addendum A, has a payment rate of \$14,743.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$8,846.15. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$8,594.92. The non-labor related portion is 40% of the APC rate or \$5,897.43. The sum of the labor and non-labor related amounts is \$14,492.35. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.294. This ratio multiplied by the billed charge of \$10,480.00 yields a cost of \$3,081.12. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$14,492.35 divided by the sum of all APC payments is 69.78%. The sum of all packaged costs is \$2,038.75. The allocated portion of packaged costs is \$1,422.64. This amount added to the service cost yields a total cost of \$4,503.76. The cost of these services exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$14,492.35. This amount multiplied by 130% yields a MAR of \$18,840.06.
  - Procedure code 63655 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0061, which, per OPPS Addendum A, has a payment rate of \$6,201.79. This amount multiplied by 60% yields an unadjusted labor-related amount of \$3,721.07. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$3,615.39. The non-labor related portion is 40% of the APC rate or \$2,480.72. The sum of the labor and non-labor related amounts is \$6,096.11. The cost of these services does not exceed the annual fixed-dollar threshold of

\$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$6,096.11. This amount multiplied by 130% yields a MAR of \$7,924.94.

- Procedure code 95972 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0692, which, per OPPS Addendum A, has a payment rate of \$110.95. This amount multiplied by 60% yields an unadjusted labor-related amount of \$66.57. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$64.68. The non-labor related portion is 40% of the APC rate or \$44.38. The sum of the labor and non-labor related amounts is \$109.06. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$109.06. This amount multiplied by 130% yields a MAR of \$141.78.
- Procedure code C1778 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1820 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1787 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1820 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.87. 125% of this amount is \$18.59
- Procedure code 80074 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$67.01. 125% of this amount is \$83.76
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.68
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.53. 125% of this amount is \$6.91
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for

Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.45. 125% of this amount is \$10.56

- Procedure code 85002 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$6.33. 125% of this amount is \$7.91
- Procedure code 86703 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$19.30. 125% of this amount is \$24.13
- Procedure code 81001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. 125% of this amount is \$5.56
- Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. This amount multiplied by 3 units is \$13.35. 125% of this amount is \$16.69
- Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. 125% of this amount is \$5.56
- Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. 125% of this amount is \$5.56
- Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. 125% of this amount is \$5.56
- Procedure code 71020 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$26.25. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$44.27. The cost of

these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$44.27. This amount multiplied by 130% yields a MAR of \$57.55.

- Procedure code 97116 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure does not have the highest paying practice expense for this date. The reduced fee listed for this code in the Multiple Procedure Payment Reduction Rate File for 2011 is \$22.56. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of \$36.21
  - Procedure code 97001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure has the highest paying practice expense for this date. The fee listed for this code in the Medicare Physician Fee Schedule is \$70.56. This amount divided by the Medicare conversion factor of 33.9764 and multiplied by the Division conversion factor of 54.54 yields a MAR of \$113.27
  - Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.36. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of \$15.90. The non-labor related portion is 40% of the APC rate or \$10.90. The sum of the labor and non-labor related amounts is \$26.80. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$26.80. This amount multiplied by 130% yields a MAR of \$34.84.
  - Procedure code 93.70 is not a valid code or was not in effect on the date the services were provided. 28 Texas Administrative Code §134.403(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Medicare payment policies require the accurate reporting of medical services using valid Healthcare Common Procedure Coding System (HCPCS) codes. Review of the submitted documentation finds that the procedure code reported is not recognized by Medicare as a valid HCPCS code for the date the services were rendered. This service does not meet the requirements of §134.403(d). Reimbursement cannot be recommended.
4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
- "GENERATOR, NEUROSTIMULATOR (IMPLANTABLE)" as identified in the itemized statement and labeled on the invoice as "Eon Mini# IPG, 16-Channel Rechargeable" with a cost per unit of \$15,990.00;
  - "GENERATOR, NEUROSTIMULATOR (IMPLANTABLE)" as identified in the itemized statement and labeled on the invoice as "Eon Mini# Charging System" with a cost per unit of \$995.00;
  - "LEAD, NEUROSTIMULATOR (IMPLANTABLE)-WC" as identified in the itemized statement and labeled on the invoice as "Penta# 3mm Lead, 60 cm" with a cost per unit of \$6,750.00;
  - "PATIENT PROGRAMMER, NEUROSTIMULATOR(W)" as identified in the itemized statement and labeled on the invoice as "Eon® Patient Programmer" with a cost per unit of \$1,395.00.

The total net invoice amount (exclusive of rebates and discounts) is \$25,130.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$1,914.00. The total recommended reimbursement amount for the implantable items is \$27,044.00.

5. The total allowable reimbursement for the services in dispute is \$54,400.87. The amount previously paid by the insurance carrier is \$9,662.69. The requestor is seeking additional reimbursement in the amount of \$40,304.43. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$40,304.43.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$40,304.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

_____	<u>Grayson Richardson</u>	<u>June 14, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	<u>June 14, 2013</u>
Signature	Medical Fee Dispute Resolution Manager	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**